URAC ACCREDITED

CLAIMS EVAL
Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 3-5-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left shoulder arthroscopic, rotator cuff repair, and subacromial decompression 29827

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

American Osteopathic Academy of Orthopedics

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MD., office visits on 9-10-09, 9-17-09 and 10-19-09.
- Physical therapy on 9-18-09, 9-24-09, 10-1-09, 10-5-09, 10-6-09.
- 10-6-09 MRI of the left shoulder.
- MD., office visits on 11-12-09 and 1-5-10.
- 12-15-09, MD., Utilization Review.
- 1-13-10, MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 9-10-09, the claimant was evaluated by MD. The claimant reports left shoulder pain. The evaluator reported x-rays of the left shoulder showed some cystic change in the lateral humeral proximal in the supraspinatus insertion area. On exam, the claimant has tenderness at the anterior shoulder. Range of motion was decreased. Strength on the left was 4/5. Diagnosis: Shoulder pain on the left, left rotator cuff syndrome. The evaluator recommended physical therapy 3 x 4, anti-inflammatory Celebrex and MRI of the left shoulder.

Follow up with Dr. on 9-17-09 notes the claimant does not have pain, but his range of motion is not there anymore. The evaluator recommended the claimant continue with physical therapy and limited work duty.

Physical therapy on 9-18-09, 9-24-09, 10-1-09, 10-5-09, 10-6-09.

Follow up with Dr. on 10-19-09 notes the review of the MRI. The evaluator felt the claimant had a left SLAP lesion, unstable, shoulder pain with was improving and rotor

cuff syndrome improving. The evaluator recommended a SLAP repair and subacromial decompression.

10-6-09 MRI of the left shoulder showed a very marked diffuse critical zone tendonitis with a superimposed bursal surface supraspinatus critical zone tear. There is also a tear of the superior articular surface fibers of the subscapularis critical zone. Mild hemi-atrophy of the subscapularis muscle is present. The superior labrum is torn anteriorly. The biceps tendon is intact but leaves the bicipital groove early. Moderate distention of the subacromial subdeltoid bursa. Marked distension of the subcoracoid bursa. Increased coracohumeral gap.

On 11-12-09, the claimant was evaluated by MD. The claimant reported he had not had physical therapy for the shoulder or surgery. The claimant reports the affected shoulder hurts, pops, and grinds, aches and has burning sensation. The claimant had similar problem in the past. The claimant reported that he recently had shoulder injury that prevented him from using it. On exam, the claimant had normal and symmetrical range of motion, impingement sign was negative. Strength was normal. Neurovascular exam was negative. X-rays of the "right" shoulder shows a type 2 acromion, normal joint space was maintained. The evaluator reported the claimant did not want surgery. The claimant was advised to do selective rest and activity modification.

On 12-15-09, MD., performed a Utilization Review. It was his opinion that the request for arthroscopic rotator cuff repair with subacromial decompression and biceps tenodesis is not recommended as medically necessary. Although the MRI study shows significant degenerative findings in the left shoulder, the patient has no remarkable functional deficits or physical exam findings on the most recent clinic note. The patient did not demonstrate positive impingement signs, rotator cuff weakness, and restricted range of motion of reduced weakness that is concordant with the findings on the MRI study. It is noted that the patient states she does not desire surgery. Based on this clinical documentation, medical necessity is not established at this time.

On 1-5-10 MD., noted the claimant reports that his pain is getting worse, the functioning of his shoulder is worse. The claimant reported his movements are worse. He feels the strength is unchanged and stability is unchanged. On exam, the claimant had tenderness at the AC joint. The claimant had normal and symmetrical passive range of motion. Impingement signs, abduction/internal rotation and abduction were negative. Strength was normal. Range of motion resisted testing was painful. The evaluator felt the claimant had a subscapularis tear, rotator cuff tear and subluxation. The evaluator recommended arthroscopic subacromial decompression, arthoscopic subscapularis repair, and arthroscopic rotator cuff repair. The claimant desired surgery.

On 1-13-10, MD., performed a Utilization Review. He noted that sustained an injury dated xx/xx/xx and complained of shoulder pain. MRI of the left shoulder dated 10-6-09 supraspinatus tear with tear and hemiatrophy of the subscapularis muscle. Anterior labral tear with intact biceps tendon, increased coracoacromial gap. Based on the submitted clinical information, the documentation of failure of conservative management

done to the patient including physical therapy progress notes, adequate pain medications and injections were not provided for review. The necessity of the requested surgical procedure was not established. Additional relevant information from a peer-to-peer contact is needed to substantiate the medical necessity of this request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The records indicated diagnostic and clinical evidence of pathology with a labral and rotator cuff tear on MRI study. The claimant has failed to improve after 6 months of treatment which has also included physical therapy. Therefore, the requested surgery is reasonable and medically indicated.

ODG-TWC, last update 2-12-10 Occupational Disorders of the Shoulder – Surgery for rotator cuff repair: Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a

well accepted and cost effective procedure. (Cordasco, 2000) Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. (Dunn, 2005) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008)
Revision rotator cuff repair: The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001)
ODG Indications for Surgery™ -- Rotator cuff repair:
Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:
1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.
Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)
1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.
(Washington, 2002)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**